

Doctors in conflict

Medicine in Ulster in relation to the great famine and “the troubles”

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See pp 1609, 1648

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In the past two centuries doctors in Ulster, and in Ireland in general, have had to face unique challenges over and above the demands of their normal practice. In the 19th century they had to endure the nightmare of the great famine, which in five years (1846-51) accounted for at least a quarter of the country's population of eight and a half million through death or emigration.^{1 2} This century they have had to deal with the consequences of the sectarian violence that has scarred Northern Ireland. Such tests have forged a profession whose integrity and clinical skills are second to none.

Medical practice in the great famine

In the great famine the cause of death was shared between diseases of nutritional deficiency (including the ultimate one of starvation) and “famine fever,” mainly typhus and relapsing fever, from which no one was immune—certainly not the 3500 physicians, surgeons, and apothecaries and the over 3000 “medical auxiliaries.” In 1849 these terrible twins were joined by the great cholera pandemic. No doctor may have actually starved to death during the famine, but in 1847 alone 131 doctors and their apprenticed pupils are known to have died from one of the rubric of “epidemic or contagious diseases”—all but a handful from “fever,” mostly contracted in the line of duty—and the mortality during the rest of the famine years is unlikely to have been substantially less (tables 1 and 2).

In 1847 this death from “fever” accounted for some 4% of all physicians, surgeons, and apothecaries in Ireland. The mortality was somewhat higher among those manning the 665 dispensaries, over 100 fever hospitals, and over 5000 fever beds in the poor law institutions, and among the attendants of the 600 000 patients who, between March 1846 and August 1850, had been treated in the so called “temporary” fever hospitals (often sheds, tents, or lean-tos, with an average patient mortality of 10.4%, average bed stay of 24 days, and at an average cost of 10 pence a day). In the same period, of the 473 additional medical officers appointed to “fever duties,” 8% had died on duty. Irish doctors had always been at high risk, prompting the aphorism, “In Ireland few medical men escape fever,” quantified by William Stokes as more than the risk of death in action among combatant officers in Wellington's armies in the Peninsula war and as higher than in the general population and in many fever hospitals,

Summary points

In the past two centuries Ulster's doctors have had to face unique challenges over and above the demands of normal practice

In Ireland's great famine many Ulster doctors lost their lives to “famine fever” and cholera while treating patients at home and in fever hospitals

During “the troubles” in Northern Ireland, health professionals have again been in the front line helping, often quite literally, to pick up the pieces

Recognition of these extraordinary demands has often been sadly lacking, exemplified by the miserly five shillings a day paid to doctors for working in the fever hospitals during the great famine

These tests, and the underlying character of Ulster society, have produced an Ulster medical profession with great cohesion and coherence and, more importantly, strengthened the existing common cultural and historical identity between doctors and patients

prompting him to conclude that fever among medical men was “eminently malignant.”

Harrowing examples crowd the pages of official reports, and in 1848 the 33 year old William Wilde, Oscar's father, who was at the time editor of the *Dublin Journal of Medical Science*, circulated a 44 item questionnaire to 70 “medical practitioners ... from whom I thought it likely [to] obtain the desired information” and published abstracts of their data and eye witness reports in the journal. These reports finally filled 280 pages of the journal^{4 5} and remain as a record on which medical and social historians of the famine, most notably Sir William McArthur,⁶ have drawn to the present day. The intentionally laconic account by Arthur Jacob in the *Dublin Medical Press* in 1847 is a good example: “The mud walls of an old cottage eked out with boarding and covered with straw formed Dr Dunne's ‘fever hospital’ in which nearly 60 patients were under his treatment at the time he contracted the fever of which he died after a few days.”

Wilde's prose was more exuberant and more charitable: "During the years 1847 and 1848, four medical men died between Clifden and Galway; three between Oranmore and Athenry, a distance of about seven miles; four more between Anadown and Kilmaln, making in all eleven ... but our professional brethren imbued with that devotion to the care of those entrusted to them, beyond self, and which has throughout the ages and never more so than in the present disastrous state, characterised their calling, did not cavil with such exigencies in pursuit of their honourable vocation." And then, ominously: "From several districts no reports have been received ... we regret to say that this has been caused by a lamentable mortality from 'fever' among our professional brethren who with so much courage devoted their energies, and too often forfeited their lives, in the discharge of their arduous duties."⁴ Health professionals must always run risks, but never in recent history in these islands have they been so great.

"The troubles"

You might think that the famine is ancient history and that modern British and Irish society could never in peacetime be so disrupted, never put the profession under such pressure, and never expose doctors to such hazards over and above the exigencies of their normal practice. However, it cannot have escaped attention that for much of the past 30 years, though mercifully less so in the past five, Northern Ireland has experienced outbreaks of politically motivated violence euphemistically referred to as "the troubles."

In a population in Northern Ireland of only 1.6 million there are by now some 3600 dead, tens of thousands injured, and thousands more evicted or intimidated from their homes, and even from the country itself. We still frequently see the obscenities of the so called "knee cappings" and "punishment" beatings and shootings, which often leave the victim maimed for life. Once again health professionals have been in the front line, helping—often quite literally—to pick up the pieces. Once again they are exposed to many of the same hazards and exigencies as are their patients. Once again the sheer magnitude and nauseating nature of much of their caseload taxes them almost beyond their limit.

No doctor to my knowledge has been killed or seriously injured in the line of duty, just as no doctor starved to death in the great famine, although hospitals and surgeries have seen violence and even the murder of patients. Neither, of course, is contagious disease now a lethal factor. What are present, however, are the immediate and long term effects of widespread physical and psychological trauma, of massive social tensions and disruptions, of the doctors' own grief, frustration, and sheer fury at the mind numbing outrages committed on their patients, and the daily evidence of man's inhumanity to man. And with all these are the practical problems of intercommunal violence disrupting the logistics and procedures of good practice in hospitals and the community—as if the perennial changes to the NHS structure and management were not disrupting enough.

The statistics are so glaring that they tend to blind and so shocking that they tend to numb. However, one

Table 1 Numbers of "medical men" and pupils who died in Ireland, by province, between 26 March 1843 and 1 January 1848 (adapted from Cusack and Stokes 1848³)

Province	1843	1844	1845	1846	1847	Total
Medical men						
Leinster	20	11	20	26	33	110
Munster	19	9	15	15	48	106
Ulster	4	9	11	20	44	88
Connaught	4	5	9	4	25	47
Unknown	2	9	10	21	30	72
Total*	49 (74)	43 (62)	65 (88)	86 (90)	180 (179)	423 (493)
Pupils						
Total*	3 (7)	1 (1)	1 (5)	4 (5)	11 (13)	20 (31)
Grand total	52 (81)	44 (63)	66 (93)	90 (95)	191 (192)	443 (524)

*Numbers in brackets are those as later revised and reproduced in the *Lancet* (1848;i:645). The revised figures for 1843 may relate to the entire year rather than nine months.

Table 2 Numbers of "medical men" and pupils who died in Ireland, by disease, between 26 March 1843 and 1 January 1848 (adapted from Cusack and Stokes 1848³)

Disease	1843	1844	1845	1846	1847	Total
"Epidemic and contagious":	19	11	20	33	131	214
"Fever"	17	11	18	30	123	199
"Sporadic"	28	27	36	44	42	177
"Violent or accidental death"	1	2	1	2	8	14
"Unspecified"	4	4	9	11	10	38
Total	52	44	66	90	191	443
% due to fever*	33	25	27	33	64	45

*May be underestimates since some of "Unspecified" deaths may also have been due to fever.

statistic can serve for many. On 17 May 1974 Alan Crockard, then a registrar at the Royal Victoria Hospital, Belfast, holding a Hunterian professorship, delivered his valedictory lecture on "Bullet injuries of the brain."⁷ He reviewed over 80 patients, most from Belfast, treated in his unit over 44 months. One has to go to Chicago—in fact to the whole of Cook County, in which Chicago stands—to find so large a peacetime series.⁸

Individual case descriptions are no less horrifying. Late in the afternoon of Saturday 4 March 1972 a bomb exploded in the crowded Abercorn Restaurant in central Belfast, killing two people outright and injuring some 130 others, including two young sisters who between them lost five limbs, a waitress who lost both legs and an eye, and a sheet metal worker who lost both legs. A senior anaesthetist at the Royal Victoria Hospital was anaesthetising casualties in the theatre when, unknown to him, the remains of his daughter, killed outright by the bomb, were wheeled down the corridor outside. One of the duty surgeons cried tears of fury and disgust at having to amputate limbs from healthy young people maimed in such a way. The carnage in Omagh in August 1998, when 28 people died and many more were injured, was not unique; it was merely the worst of many.

The health professions, like many others, have risen superbly to these challenges. Their commitment is not to be measured by counting their tombstones, as with the doctors in the great famine, but by the high repute in which they are held; the gratitude shown by the many victims and their kin; their widely acknowledged skills and their superb results; their cohesion, integrity, and high morale; and the fact that Belfast has become a world leader in the treatment of trauma. Between 1968 and 1995 the staff at the Royal Victoria Hospital have written or edited nearly 200 articles, book chapters, and proceedings solely about trauma related



Many doctors died of "epidemic or contagious diseases" during the great famine (1846-51)

to "the troubles," as well as the many talks, lectures, symposiums, seminars, and other communications that did not reach publication (data compiled from Royal Victoria Hospital archive by hospital archivist, Professor RSJ Clarke). All this on top of the normal case reporting and research that are the stuff of busy teaching hospitals with clinical academic units.

Lack of recognition

I don't believe that the profession's response could have been bettered, but I am not satisfied that my colleagues' achievements have been fully recognised outside the profession and the swollen ranks of their grateful patients. This is the irony that professional competence shares with the plumbing—you notice it only when it fails. In this sense the Ulster profession is a victim of its own success: by minimising the medical results of the problems by their skill, doctors are forgotten by the public. General recognition has been modest. Some colleagues, mainly those with university attachments, have received civil recognition through the honours system and in other ways, but this is for their professional standing and academic achievements. Few have had citations specifying "the troubles."

But it has always been thus. In the great famine doctors were given only five shillings a day to risk their lives attending the fever hospitals—those ante-chambers of death that did for the hapless Dr Dunne and so many other doctors—while the tradesmen who built or converted these sheds often got more. Nearly half the national profession signed a petition to the lord lieutenant in 1849 requesting more money; but without success. The government justified its parsimony by citing the views of the de facto chairman of the Central Board of Health, the Dublin luminary Dr Dominic Corrigan. Corrigan was motivated by high idealism, believing danger to be intrinsic to a medical calling and therefore unremarkable and certainly not to be especially compensated, a view that not all his beleaguered colleagues had the altruism to share. J O Curran, professor of medicine at Apothecaries Hall, was among those who contemptuously refused the five shillings. He duly died of fever and was viewed as a martyr in a special panegyric by Wilde in the *Dublin Journal of Medical Science*. In fairness, Corrigan drove himself remorselessly at the Central Board of Health

and carried out his clinical duties at the Hardwick Fever Hospital in the centre of Dublin, constantly exposed to fever, in a brave and exemplary manner. Hopefully, professional discretionary and other confidential awards are currently redressing some of the balance among the Ulster profession.

Character of Ulster medicine

The superb response of the local profession to the troubles has its roots in its professionalism and in certain distinctive features of Ulster medicine and its practitioners.⁹ The Northern Ireland profession is composed overwhelmingly of Ulster men and women, mostly graduates of Queen's University. It is the heir to a pragmatic and clinically oriented tradition, a laudable ethos whose genesis lies in the sense of values of the Ulster society that spawned it. Traditionally, this society has placed a premium on practical skills and has provided, and to an extent still provides, the robust, self-reliant, often puritan, and unsophisticated milieu of a rural, even frontier, society. Its members have little appetite for affecting the philosophies and mores of their metropolitan cousins or even, until recently, in constructing a deeply rooted bourgeoisie, and its medical sons and daughters have thought likewise.

Such a society values education as a means of advancement, and in Ulster this has been fortified with the strong Irish and Scottish emphasis on learning for its own sake. Ulster doctors of social conscience and cultural or intellectual bent turned their energies to founding schools, self-improvement societies, scientific bodies, museums, and such like, rather than endowing art galleries, fine arts societies, or the performing arts. They were taken by the practicalities, not the abstractions or adornments of life. They were educators, improvers, "levellers" of opportunity (though not reward), and, above all, doers. They were, at best, intellectually of the Scottish Enlightenment and had no pretence to be Renaissance men, and they scorned many of what they saw as the effete practices and hidebound values of the cultural oligarchies and the "big house" societies.

Three of the previous four Ulster presidents of this association took medical education as a main topic in their address; two even specified it in the title.^{10 11} Clinical, ethical, and teaching standards have accordingly always been high, and our only medical school, that of Queen's University, consistently lies in the top tenth of GMC ratings for teaching, examining, and syllabus organisation. Against this, however, it has not received high scores from the University Funding Council for research, whose modern requirements are not easily obtained in provincial isolation and are not in any event highly prioritised by the type of society I have described. Exceptional colleagues have won international research reputations, but research is not our strongest feature.

The local profession is also highly committed and compassionate. Good and bad doctors are to be found everywhere, and Ulster is no exception; but here there is a professional cohesion and coherence not always present elsewhere and, more importantly, a common cultural and historical identity between doctors and patients. Ulster's doctors were never Oxbridge or Pall Mall gentlemen, nor were they members of the

talented but exclusive oligarchy of the Anglo-Irish ascendancy, as were many of the luminaries in Dublin medicine's great years. No Ulster medical journal ever included theatre reviews and chess problems, as did the *Lancet* in its early days for the metropolitan "gentleman-physician." Nor were Ulster doctors of patrician families relying on high birth, patronage, or nepotism for their careers. They and their patients alike were of the fields and streets of Ulster, of common culture, heritage, and sense of values—social equals different only in their professional skills and calling. Ulster doctors know their patients because they know themselves. There has, of course, been potentially vitiating cultural, even biological, inbreeding, but this has been diluted sufficiently by talented imports, especially since the second world war, to ensure hybrid vigour. Without understanding all this, the outsider would consider the Ulster profession to be like the sculpture "The Winged Victory of Samothrace," a deftly crafted body but without a head. If Ulster society, history, and temperament combine to produce periodic "troubles,"

they also, by a compensating gift, produce a profession eminently qualified to deal with the results.

Article based on the presidential address by PF at the BMA's annual representative meeting, Belfast, 7 July 1999.

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Conflict in Bosnia 1992-3

Sir Donald Acheson

After retiring as chief medical officer for England in late 1991, Sir Donald Acheson—who describes himself as "intellectually exhausted" at the time—might have been forgiven for looking forward to a relaxing retirement. Instead the WHO Regional Director for Europe, Jo Asvall, persuaded him to go to former Yugoslavia as his special representative. His mission was to evaluate what public health issues were developing in Bosnia, a country newly wracked by war.

Sir Donald set up an office in Zagreb, the capital of Croatia, in July 1992. At the time Zagreb was thought to be much safer than Sarajevo in Bosnia. After the invasion of Croatia by Serbia the year before (which had ended with the Vance-Owen Agreement), Bosnia had become the next scene of unrest. When Sir Donald arrived, Sarajevo, with a mixed population of some 350 000 Serbs, Croats, and Muslims living in relative harmony for hundreds of years, had been under siege for three months.

Although Sir Donald was horrified by much of what he saw in Bosnia, he was not afraid. Coming as he does from Belfast, he understands the concept of ethnic division, where people who look the same as each other break into warring factions.

9 July 1992—en route from Copenhagen to Geneva

On my way to Zagreb as Special Representative of the WHO Regional Director for three months. Am currently in a flight from Copenhagen to Geneva for briefing in both places. The other agencies are UNHCR and Unicef and the International Red Cross. My instructions are to meet the other UN officials and all the health ministers of the new states. But of course the big question is what comes next and whether this is window dressing.

10 July 1992—Zagreb, Croatia

The key issues (or a few of them) are:

- (a) current state of health: (i) in camps; (ii) in UN protected areas; (iii) in besieged cities; (iv) elsewhere.
- (b) what will happen next winter, bearing in mind that it is very cold here and many of those currently being looked after by friends or relatives with a government support system are likely to be put out as soon as the system of support has stopped—very soon. But nutrition is good.
- (c) Whether or how a "sentinel" system can be set up of health or healthcare provision.

An epidemiologist from the Centers for Disease Control reminded me that the key problems are likely to be diarrhoea and respiratory illnesses and that excess mortality can be assessed on the basis of (roughly) a norm of 1 per 10 000 per day. Meningitis may also be a problem. I said typhus might [also] and was proved right by a report that it is occurring in Sarajevo [it was not, however, confirmed] I met Mme Anne-Marie Demmer, director of the European Bureau of UNHCR. She seemed rather overwhelmed by the Yugoslavian situation, particularly its scale and the problem of getting winterproof accommodation set up in time. She feels that at all costs the "mental consequences of the war" (a further generation of disastrous bitterness and prejudice) should be averted by "rehabilitation." I wonder how this could be undertaken with any hope of success.

12 July 1992—Zagreb, Croatia

Have just had an interesting conversation with a Croat engineer returning to Zagreb from Paris. Slightly older than I but fought with Tito and met Randolph Churchill in 1942. His name is Vinko Arambasin. He

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